not counted. In reality the provision and delivery of health care coincides with consumption and cannot be separated, in particular in emergency contexts. Procedures and treatments cannot be stored like products of the manufacturing or drug industries; it is rather a matter of oversupply or undersupply of facilities and personnel in relation to health care needs or demands. It follows that the subjects of cost effectiveness evaluation as conceptualised in the book mainly are elective procedures. The effects of hospital teaching status on the outcome of acute myocardial infarction have been shown to be large. The authors use the classic assumptions of advantages of scale economies and scope economies omitting the recognised fact that there are diseconomies of scale in hospitals.² The evidence on the effects of the hospital teaching status and scale on outcomes compared with costs would deserve some comments. It is possible that the economic evaluation would

appeal a broader audience if its examples extended behind "whether drugs or surgery are the most cost-effective ways of treating angina".¹

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CORRECTION

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This is an amended version of a correction that appeared in the August issue of the journal (2006;60:735)

In our March 2006 issue, Oscar H Franco and colleagues discussed the concept of a fixed dose combination pill, which was referred to as a polypill, a theoretical combination of six pharmacological compounds for the treatment of cardiovascular disease proposed by N J Wald and M R Law in their article, "A strategy to reduce cardiovascular disease by more than 80%" (*BMJ* 2003;326:1419). We would like to make it clear that Franco *et al*'s article was a discussion of the theoretical concept of a fixed dose combination pill as proposed in Wald and Law's article and did not intend in any way to refer to POLYPILL, a term that is currently the subject of trade mark applications by Professor Wald in the USA and Canada. The Editors wish to apologise to Professor Wald for any ambiguity that may have occurred in the wording of this article.

Speaker's corner

Emerging issues in public health information

In recent years, two issues have emerged concerning the collection of public health information: the increasing popularity of mobile cellular telephones (cell phones), and the increasing interest of governments in protecting the privacy and confidentiality of their citizens' health information. These issues have widespread, longlasting, and potentially adverse effects on certain aspects of public health research and practice.

Public health researchers and practitioners have increasingly relied on the use of computer assisted telephone interviewing (CATI) to collect public health information. The use of such telephone surveys is a cost effective method with which to access large samples quickly. However, the popularity of cell phones is emerging as a potential problem in CATI survey design because people in households with cell phones and no conventional landline telephone would be excluded from telephone survey sampling frames based on telephone directories or electronic white pages, thus creating a sampling bias. Although random digit dialling (RDD) can reach cell phone users, the existence of multiple cell phone numbers in the same household would increase the likelihood that a household would be selected to participate in the survey. In addition, refusal rates would probably be higher among cell phone users selected, as they tend to be on the go, and in many countries they must pay to receive incoming calls. One might argue that survey results will not be biased by multiple cell phones in a household as long as that household has a landline, but even this would not be true if the presence of the cell phones would make household members less likely to pick up a call on the landline phone. The increasing popularity of cell phones, therefore, may mean that the usefulness of the telephone/CATI survey technology in collecting public health information may be nearing an end.

Concerns about protecting the confidentiality of individual health information may also affect public health information systems. Public health researchers and practitioners in general have no reason to release confidential health information to the general public. However, they do need access to such confidential information, to conduct studies to identify risk factors and develop prevention and control strategies for the public good. In many countries, recent legislation designed to

prevent "leakage" of confidential health information has restricted information flow to the extent that public health researchers and practitioners find it difficult to conduct any meaningful epidemiological studies because of an inability to link records. Because public health researchers and practitioners need access to this information to do their job, we hope that new privacy and confidentiality legislation can stop unnecessary information leakage while permitting efficient information flow among public health researchers and practitioners.

Although cell phones have not yet driven conventional telephones out of business, public health researchers need to consider using multi-mode designs for data collection, perhaps a combination of conventional telephone, web based, mailed, face to face, and cell phone surveys. They will also need to address related statistical issues such as how to blend the results of cell phone surveys with the results of traditional surveys, as they tend to reach different population subgroups. The public health challenge is to collect valid and reliable public health data at a reasonable cost and in a timely manner. The solution to concerns about protecting the privacy of individual health information may be as simple as making a law that imposes a stiff penalty on whoever releases or misuses personal data. Public health researchers and practitioners need data and access to confidential information, but if this privilege is misused there can be important financial and legal implications for the society.

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The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Public Health Agency of Canada, the Universities of Toronto and Ottawa, and the US Centers for Disease Control and Prevention.